UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

RELISTOR (methylnaltrexone)

Patient name:_____Medicaid or SS#_____
Physician Name:_____Contact person:_____
Phone#:_____Ext. and opt._____Fax#_____
Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO: 801-536-0477

CRITERIA:

- Minimum age requirement 18 years old
- Diagnosis of opioid-induced constipation
- Rule out mechanical GI obstruction
- Patient must be receiving opioids as part of a palliative care regimen for advanced illness.
- Documented trial and failure of conventional laxative therapy.

AUTHORIZATION:

4 months

RE-AUTHORIZATION:

Telephone call from physician's office or pharmacy.

01/28/2009